



# TENNESSEE DEPARTMENT OF HEALTH

Health Statistics  
2nd Floor, Andrew Johnson Tower  
710 James Robertson Parkway  
Nashville, TN 37243  
Telephone: (615) 741-1954 - Fax: (615) 253-1688

## JOINT ANNUAL REPORT OF HOSPITALS

2013

Schedule	Description	Page Number
A.	Identification	2
B.	Classification	3
C.	Accreditations and Approvals	5
D.	Services	6
E.	Financial Data	18
F.	Beds and Bassinets	22
G.	Utilization	24
H.	Psychiatric, Chemical Dependency	32
I.	Emergency Department	36
J.	Personnel	39
K.	Medical Staff	40
L.	Perinatal	41
M.	Nursing Survey	42
N.	Health Care Plans	43

TENNESSEE DEPARTMENT OF HEALTH  
JOINT ANNUAL REPORT OF HOSPITALS

2013

SCHEDULE A - IDENTIFICATION\*

1. Name of Hospital Baptist Memorial Hospital - Huntingdon Federal Tax I.D. # 62-1166050  
 Did your facility name change during the reporting period? ☐ YES ☒ NO  
 County Carroll
2. Address of Street 631 R. B. Wilson Drive  
 Facility City Huntingdon State Tennessee Zip 38344-
3. Telephone Number (731) 986-4461  
 Area Code Number
4. Name of Chief Executive Officer Susan Breeden  
 First Name Last Name  
 Signature of Chief Executive Officer \_\_\_\_\_
5. Name of person(s) coordinating form completion Sharron Holland  
 Telephone Number if different than above (731) 986-7280  
 Area Code Number
6. 0 Office Use Only
7. Reporting period used for this facility:  
 Beginning Date 10/01/2012 Ending Date 09/30/2013
8. 365 Office Use Only
9. Does your hospital own or operate or have other hospitals licensed as satellites of your hospital? ☐ YES ☒ NO  
 If yes, please complete the following.

	NAME OF HOSPITAL	STATE ID	SATELLITE	OWN	OPERATE	OWN AND OPERATE
1	_____	_____	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2	_____	_____	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3	_____	_____	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4	_____	_____	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5	_____	_____	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## SCHEDULE B - CLASSIFICATION\*

State ID 09245

## 1. CONTROL:

A. Indicate the type of organization that is responsible for establishing policy for overall operation of the hospital.

- |   |  |   |                                      |
|---|--|---|--------------------------------------|
| <u>1. Government-Non-Federal</u>                        | <u>2. Government-Federal</u>                         | <u>3. Nongovernmental, not-for-profit</u>                           | <u>4. Investor-owned, for-profit</u> |
| <input type="radio"/> 11 State                          | <input type="radio"/> 17 Armed Forces                | <input type="radio"/> 20 Church-operated                            | <input type="radio"/> 23 Individual  |
| <input type="radio"/> 12 County                         | <input type="radio"/> 18 Veterans Admin.             | <input checked="" type="radio"/> 21 Other Nonprofit Corporation     | <input type="radio"/> 24 Partnership |
| <input type="radio"/> 13 City                           | <input type="radio"/> 19 Other, please specify _____ | <input type="radio"/> 22 Other not-for-profit, please specify _____ | <input type="radio"/> 25 Corporation |
| <input type="radio"/> 14 City-County                    |  |   |                                      |
| <input type="radio"/> 15 Hospital district or authority |  |   |                                      |

B. Is the hospital part of a health system? ☒ YES ☐ NO

If yes, please provide the name and location of the health system.

Name Baptist Memorial Healthcare System City Memphis State TennesseeC. Does the controlling organization lease the physical property from the owner(s) of the hospital? ☐ YES ☒ NO

D. What is the name of the legal entity that owns and has title to the land and physical plant of the hospital?

Baptist Memorial Healthcare CorporateionE. Is the hospital a division of a holding company? ☐ YES ☒ NOF. Does the hospital itself operate subsidiary corporations? ☐ YES ☒ NOG. Is the hospital managed under contract? ☐ YES ☒ NO If YES, length of contract From \_\_\_\_\_ To \_\_\_\_\_

If yes, please provide name, city, and state of the organization that manages the hospital.

Name _____	City _____	State _____
Name _____	City _____	State _____

H. Is the hospital part of a health care alliance? ☒ YES ☐ NO (see definition of alliance)

If yes, please provide the name, city, and state of the alliance headquarters.

Name <u>Voluntary Hospitals of America</u>	City <u>Irving</u>	State <u>Texas</u>
Name _____	City _____	State _____

I. Is the hospital part of a health network? ☒ YES ☐ NO (see definition of network)

If yes, please provide the the name, city, and state of the network.

Name <u>Baptist Health Services Group</u>	City <u>Memphis</u>	State <u>Tennessee</u>
Name _____	City _____	State _____

## 2. SERVICE:

A. Indicate the ONE category that BEST describes your hospital.

- |  |   |
|--|---|
| <input checked="" type="radio"/> 01 General medical and surgical     | <input type="radio"/> 07 Rehabilitation                           |
| <input type="radio"/> 02 Pediatric                                   | <input type="radio"/> 08 Orthopedic                               |
| <input type="radio"/> 03 Psychiatric                                 | <input type="radio"/> 09 Chronic disease                          |
| <input type="radio"/> 04 Tuberculosis and other respiratory diseases | <input type="radio"/> 10 Alcoholism and other chemical dependency |
| <input type="radio"/> 05 Obstetrics and gynecology                   | <input type="radio"/> 11 Long term acute care                     |
| <input type="radio"/> 06 Eye, ear, nose and throat                   | <input type="radio"/> 12 Other-specify treatment area _____       |

SCHEDULE B - CLASSIFICATION (continued)\*

State ID 09245

B. Does your hospital own or have a contract with any of the following?

	(1) Yes	(2) No	Specify one:		Number of Physicians	FTE Physicians
			1) Own	2) Contract		
1. Independent Practice Association	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>0</u>	<u>0.0</u>
2. Group Practice Without Walls	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>0</u>	<u>0.0</u>
3. Open Panel Physician-Hospital Organization (PHO)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>0</u>	<u>0.0</u>
4. Closed Panel Physician-Hospital Organization (PHO)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>0</u>	<u>0.0</u>
5. Management Services Organization (MSO)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>0</u>	<u>0.0</u>
6. Integrated Salary Model	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>0</u>	<u>0.0</u>
7. Equity Model	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>0</u>	<u>0.0</u>
8. Foundation	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>0</u>	<u>0.0</u>

3. Have any of the following insurance products been developed for use in Tennessee by your hospital, health system, health network alliance or as a joint venture with an insurer?

**Check all that apply.**

	Your			Joint Venture	
	(1) Hospital	(2) Health System	(3) Health Network	(4) Alliance	(5) With Insurer
A. Health Maintenance Organization	(1) <input type="checkbox"/>	(2) <input type="checkbox"/>	(3) <input type="checkbox"/>	(4) <input type="checkbox"/>	(5) <input type="checkbox"/>
B. Preferred Provider Organization	(1) <input type="checkbox"/>	(2) <input type="checkbox"/>	(3) <input type="checkbox"/>	(4) <input type="checkbox"/>	(5) <input type="checkbox"/>
C. Indemnity Fee For Service Plan	(1) <input type="checkbox"/>	(2) <input type="checkbox"/>	(3) <input type="checkbox"/>	(4) <input type="checkbox"/>	(5) <input type="checkbox"/>

4. Does your hospital have a formal written contract that specifies the obligations of each party with:

A. Health Maintenance Organization (HMO)? ☒ YES ☐ NO

1. How many do you contract with? 9

2. Number of different contracts 12

B. Preferred Provider Organization (PPO)? ☒ YES ☐ NO

1. How many do you contract with? 72

2. Number of different contracts 78

5. What percentage of the hospital's net patient revenue is paid on a capitated basis?

If the hospital does not participate in any capitated arrangement, please enter "0". 0.0 %

6. How many covered lives are in your capitation agreements? 0

SCHEDULE C - ACCREDITATIONS AND APPROVALS\*

State ID 09245

1. ACCREDITATIONS:

A. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Date of most recent accrediting letter or survey 03/16/2012

☒ YES ☐ NO

If Yes, Is the hospital accredited under either/both of the following manuals:

1. Comprehensive Accreditation Manual for Hospitals (CAMH)

☒ YES ☐ NO

2. Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)

☐ YES ☒ NO

3. Other manuals, please specify \_\_\_\_\_

B. Commission on Accreditation of Rehabilitation Facilities (CARF)

Date of most recent accrediting letter or survey \_\_\_\_\_

☐ YES ☒ NO

C. American College of Surgeons Commission on Cancer

☐ YES ☒ NO

D. American Osteopathic Association (AOA)

☐ YES ☒ NO

E. TÜV Healthcare Specialists

☐ YES ☒ NO

F. Community Health Accreditation Program (CHAP)

☐ YES ☒ NO

2. CERTIFICATIONS:

Medicare Certification

☒ YES ☐ NO

3. OTHER:

A. THA Membership

☒ YES ☐ NO

B. Hospital Alliance of Tennessee, Inc. Membership

☐ YES ☒ NO

C. American Hospital Association Membership

☒ YES ☐ NO

D. American Medical Association Approval for Residencies (and Internships)

☐ YES ☒ NO

E. State Approved School of Nursing:

Registered Nurses

☐ YES ☒ NO

Licensed Practical Nurses

☐ YES ☒ NO

F. Medical School Affiliation

☐ YES ☒ NO

G. Tennessee Association of Public and Teaching Hospitals (TNPath)

☐ YES ☒ NO

H. National Association of Children's Hospitals and Related Institutions (NACHRI)

☐ YES ☒ NO

I. National Association of Public Hospitals (NAPH)

☐ YES ☒ NO

J. Other, please specify \_\_\_\_\_

Field is limited to 255 characters

## SCHEDULE D - SERVICES\*

State ID 09245

## 1. CERTIFICATE OF NEED:

Do you have an approved, **but not completed**, certificate of need (CON) ? ☒ YES ☐ NO

If yes, please specify:

Name of Service or Activity Requiring the CON	# of Beds (if applicable)	Date of Approval
Psychiatric	12	09/26/2012
	0	
	0	

2. Does your hospital own or operate Tennessee physician primary care clinics? ☐ YES ☒ NO If yes, how many? 0How many physicians practice in these clinics? 03. Does your hospital own or operate other physician/specialty clinics located in Tennessee? ☐ YES ☒ NO If yes, how many? 0How many physicians practice in these clinics? 04. Does your hospital own or operate a blood bank? ☐ YES ☒ NO

If yes, please indicate:

A. Distributes blood within the hospital ☐ YES ☒ NOB. Collects blood within the hospital ☐ YES ☒ NOC. Distributes blood outside the hospital ☐ YES ☒ NOD. Collects blood from outside the hospital ☐ YES ☒ NO5. Does your hospital own or operate an ambulance service? ☒ YES ☐ NO

If yes, please specify the counties where services are located.

Carroll

Please specify the type of service and ownership relationship:

A. Land Transport ☒ YES ☐ NO If yes, ☐ own; ☐ operate; ☒ own and operate; ☐ own in joint ventureB. Helicopter ☐ YES ☒ NO If yes, ☐ own; ☐ operate; ☐ own and operate; ☐ own in joint ventureC. Special Neonatal Helicopter ☐ YES ☒ NO If yes, ☐ own; ☐ operate; ☐ own and operate; ☐ own in joint ventureD. Special Neonatal Land Transport ☐ YES ☒ NO If yes, ☐ own; ☐ operate; ☐ own and operate; ☐ own in joint venture

SCHEDULE D - SERVICES (continued)\*

State ID 09245

6. Does your hospital own or operate an off-site outpatient/ambulatory clinic located in Tennessee? ☐ YES ☒ NO

If yes, please complete the following.

<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture
_____	_____	_____	_____
Name of Clinic	County	City	
_____	_____	_____	_____
Name of Clinic	County	City	

7. Does your hospital own or operate an off-site ambulatory surgical treatment center located in Tennessee? ☐ YES ☒ NO

If yes, please complete the following.

<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture
_____	_____	_____	_____
Name of Center	County	City	
_____	_____	_____	_____
Name of Center	County	City	

8. Does your hospital own or operate an off-site birthing center located in Tennessee? ☐ YES ☒ NO

If yes, please complete the following.

<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture
_____	_____	_____	_____
Name of Center	County	City	
_____	_____	_____	_____
Name of Center	County	City	

9. Does your hospital own or operate an off-site outpatient diagnostic center located in Tennessee? ☐ YES ☒ NO

If yes, please complete the following.

<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture
_____	_____	_____	_____
Name of Center	County	City	
_____	_____	_____	_____
Name of Center	County	City	

10. Does your hospital own or operate an off-site outpatient physical therapy rehab center located in Tennessee? ☐ YES ☒ NO

If yes, please complete the following.

<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture
_____	_____	_____	_____
Name of Center	County	City	
_____	_____	_____	_____
Name of Center	County	City	

SCHEDULE D - SERVICES (continued)\*

State ID 09245

11. Does your hospital own or operate a hospice that has a separate license located in Tennessee? ☒ YES ☐ NO

If yes, please complete the following.

<u>Baptist Home Care and Hospice</u>	<u>Carroll</u>	<u>Huntingdon</u>	<input type="radio"/> own	<input type="radio"/> operate	<input checked="" type="radio"/> own and operate	<input type="radio"/> own in joint venture
Name of Hospice	County	City				
<u></u>	<u></u>	<u></u>	<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture
Name of Hospice	County	City				

12. Does your hospital own or operate an off-site assisted-care living facility located in Tennessee? ☐ YES ☒ NO

If yes, please complete the following.

<u></u>	<u></u>	<u></u>	<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture
Name of Facility	County	City				
<u></u>	<u></u>	<u></u>	<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture
Name of Facility	County	City				

13. Does your hospital own or operate a home for the aged located in Tennessee? ☐ YES ☒ NO

If yes, please complete the following.

<u></u>	<u></u>	<u></u>	<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture
Name of Home	County	City				
<u></u>	<u></u>	<u></u>	<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture
Name of Home	County	City				

14. Does your hospital own or operate an urgent care center? ☐ YES ☒ NO

If yes, please complete the following.

<u></u>	<u></u>	<u></u>	<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture
Name of Center	County	City				
<u></u>	<u></u>	<u></u>	<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture
Name of Center	County	City				

15. Does your hospital own or operate a home health agency? ☒ YES ☐ NO

If yes, please complete the following.

Name of Agency: Baptist Home Care and Hospice

Location of Agency: City Huntingdon County Carroll

Number of Visits 4,816

☐ own ☐ operate ☒ own and operate ☐ own in joint venture

Name of Agency: \_\_\_\_\_

Location of Agency: City \_\_\_\_\_ County \_\_\_\_\_

Number of Visits \_\_\_\_\_

☐ own ☐ operate ☐ own and operate ☐ own in joint venture



SCHEDULE D - SERVICES (continued)\*

State ID 09245

16. Does your hospital own or operate an off-site nursing home located in Tennessee? ☐ YES ☒ NO

If yes, please complete the following.

\_\_\_\_\_ ☐ own ☐ operate ☐ own and operate ☐ own in joint venture  
 Name of Home County City  
 Number of Beds - Total 0 = Medicare only (SNF) \_\_\_\_\_ + Medicaid only (NF) \_\_\_\_\_ + Medicare/Medicaid (SNF/NF) \_\_\_\_\_ + Not Certified \_\_\_\_\_

\_\_\_\_\_ ☐ own ☐ operate ☐ own and operate ☐ own in joint venture  
 Name of Home County City  
 Number of Beds - Total 0 = Medicare only (SNF) \_\_\_\_\_ + Medicaid only (NF) \_\_\_\_\_ + Medicare/Medicaid (SNF/NF) \_\_\_\_\_ + Not Certified \_\_\_\_\_

17. Does your hospital operate a hospital-based skilled nursing unit (subacute unit) licensed as a nursing home for skilled nursing care (excluding swing beds)? ☐ YES ☒ NO If yes, please complete the following.

\_\_\_\_\_  
 Name of SNF  
 \_\_\_\_\_ Number of Licensed Beds \_\_\_\_\_ Number of Staffed Beds  
 \_\_\_\_\_  
 \_\_\_\_\_ Number of Admissions \_\_\_\_\_ Number of Patient Days

18. Does your hospital own, operate, or contract a mobile unit that operates in Tennessee? ☐ YES ☒ NO

If yes, specify name(s) and whether owned, operated, or contracted.

A. List mobile services:

1 _____	<input type="radio"/> contract	<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture	_____ # of visits
2 _____	<input type="radio"/> contract	<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture	_____ # of visits
3 _____	<input type="radio"/> contract	<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture	_____ # of visits
4 _____	<input type="radio"/> contract	<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture	_____ # of visits
5 _____	<input type="radio"/> contract	<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture	_____ # of visits
6 _____	<input type="radio"/> contract	<input type="radio"/> own	<input type="radio"/> operate	<input type="radio"/> own and operate	<input type="radio"/> own in joint venture	_____ # of visits

B. List counties served (where you take the service):

**List counties for service 1 in 18A on line 1, for service 2 on line 2, etc.**

1 _____	_____	_____	_____	_____	_____	_____
2 _____	_____	_____	_____	_____	_____	_____
3 _____	_____	_____	_____	_____	_____	_____
4 _____	_____	_____	_____	_____	_____	_____
5 _____	_____	_____	_____	_____	_____	_____
6 _____	_____	_____	_____	_____	_____	_____

SCHEDULE D - SERVICES (continued)\*

State ID 09245

19. HOSPITAL-BASED SERVICES (See Explanation):

Utilization of Selected Services	Is This Service Provided In Your Hospital?		To Inpatients		To Outpatients	
	YES	NO	Unit of Measure	Number	Unit of Measure	Number
<b>A. Miscellaneous:</b>						
Lithotripsy						
Percutaneous	<input type="radio"/>	<input checked="" type="radio"/>	Procedures	<u>0</u>	Procedures	<u>0</u>
Extracorporeal Shock Wave	<input type="radio"/>	<input checked="" type="radio"/>				
# fixed units inside hospital <u>0</u>			Procedures	<u>0</u>	Procedures	<u>0</u>
# fixed units off site <u>0</u>					Procedures	<u>0</u>
# of mobile units <u>0</u>			Procedures	<u>0</u>	Procedures	<u>0</u>
# days per week (mobile units) <u>0</u>						
Renal Dialysis						
# of dedicated stations <u>0</u>						
Hemo Dialysis	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>	Patients	<u>0</u>
			Treatments	<u>0</u>	Treatments	<u>0</u>
Peritoneal Dialysis	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>	Patients	<u>0</u>
			Treatments	<u>0</u>	Treatments	<u>0</u>
<b>B. Oncology/Therapies:</b>						
Chemotherapy	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>	Patients	<u>0</u>
					Encounters	<u>0</u>
Hyperthermia	<input type="radio"/>	<input checked="" type="radio"/>	Treatments	<u>0</u>	Treatments	<u>0</u>
Radiation Therapy-Megavoltage	<input type="radio"/>	<input checked="" type="radio"/>				
# fixed units inside hospital <u>0</u>			Patients	<u>0</u>	Patients	<u>0</u>
			Treatments	<u>0</u>	Treatments	<u>0</u>
# fixed units off site <u>0</u>						

SCHEDULE D - SERVICES (continued)\*

State ID 09245

Utilization of Selected Services	Is This Service Provided In Your Hospital?		To Inpatients		To Outpatients	
	YES	NO	Unit of Measure	Number	Unit of Measure	Number
<b>C. Radiology:</b>						
Computerized Tomographic Scanners CT/CAT	<input checked="" type="radio"/>	<input type="radio"/>	Patients	212	Visits	1,517
# fixed units inside hospital 1			Procedures	267	Procedures	1,715
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Ultrafast CT	<input type="radio"/>	<input checked="" type="radio"/>	Patients	0	Visits	0
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Magnetic Resonance Imaging	<input checked="" type="radio"/>	<input type="radio"/>				
# fixed units inside hospital 1			Procedures	62	Procedures	882
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	143	Procedures	0
# days per week (mobile units) 0						
Nuclear Medicine	<input checked="" type="radio"/>	<input type="radio"/>	Procedures	6	Procedures	185
Radium Therapy	<input type="radio"/>	<input checked="" type="radio"/>	Procedures	0	Procedures	0
Isotope Therapy	<input type="radio"/>	<input checked="" type="radio"/>	Procedures	0	Procedures	0
Positron Emission Tomography	<input type="radio"/>	<input checked="" type="radio"/>				
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Mammography	<input checked="" type="radio"/>	<input type="radio"/>	Procedures	0	Procedures	881
# of ACR accredited units 1						
# other fixed units inside hospital 0						
# other fixed units off site 0						
# of mobile units 0						
# days per week (mobile units) 0						
Bone Densitometry	<input type="radio"/>	<input checked="" type="radio"/>	Procedures	0	Procedures	0
# of units 0						

SCHEDULE D - SERVICES (continued)\*

State ID 09245

Note: Pediatric patients should be defined as patients 14 years old and younger.

Utilization of Selected Services	Is This Service Provided In Your Hospital?		In Cath Lab Setting		Outside Cath Lab Setting	
	YES	NO	Unit of Measure	Number	Unit of Measure	Number
<b>D. Cardiac:</b>						
Cardiac Catheterization						
Date Initiated _____						
# labs _____ 0						
Intra-Cardiac or Coronary Artery	<input type="radio"/>	<input checked="" type="radio"/>	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
Percutaneous Transluminal Coronary Angioplasty	<input type="radio"/>	<input checked="" type="radio"/>	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
Stents	<input type="radio"/>	<input checked="" type="radio"/>	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
All Other Heart Procedures	<input type="radio"/>	<input checked="" type="radio"/>	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
All Other Non-Cardiac Procedures	<input type="radio"/>	<input checked="" type="radio"/>	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
Thrombolytic Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
			<u>To Inpatients</u>		<u>To Outpatients</u>	
Open Heart Surgery	<input type="radio"/>	<input checked="" type="radio"/>	Adult Operations	0		
# dedicated O.R.'s _____ 0			Pediatric Operations	0		
<b>E. Surgery:</b>						
Inpatient	<input checked="" type="radio"/>	<input type="radio"/>	Encounters	38		
# operating rooms _____ 2			Procedures	38		
Outpatient (one day)	<input checked="" type="radio"/>	<input type="radio"/>			Encounters	243
# dedicated O.R.'s _____ 0					Procedures	243
<b>F. Rehabilitation:</b>						
Cardiac	<input checked="" type="radio"/>	<input type="radio"/>	Patients	0	Patients	46

SCHEDULE D - SERVICES (continued)\*

State ID 09245

Utilization of Selected Services	Is This Service Provided In Your Hospital?		To Inpatients		To Outpatients	
	YES	NO	Unit of Measure	Number	Unit of Measure	Number
<b>F. Rehabilitation (continued):</b>						
Chemical Dependency	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>	Patients	<u>0</u>
			Episodes of Care	<u>0</u>	Episodes of Care	<u>0</u>
Nutritional Counseling	<input checked="" type="radio"/>	<input type="radio"/>	Patients	<u>938</u>	Patients	<u>40</u>
			Episodes of Care	<u>40</u>	Episodes of Care	<u>40</u>
Pulmonary	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>	Patients	<u>0</u>
			Episodes of Care	<u>0</u>	Episodes of Care	<u>0</u>
<b>G. Physical Rehabilitation:</b>						
Occupational Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Patients	<u>0</u>	Patients	<u>0</u>
			Episodes of Care	<u>0</u>	Episodes of Care	<u>0</u>
Orthotic Services	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>	Patients	<u>0</u>
			Episodes of Care	<u>0</u>	Episodes of Care	<u>0</u>
Physical Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Patients	<u>181</u>	Patients	<u>556</u>
			Episodes of Care	<u>898</u>	Episodes of Care	<u>898</u>
Prosthetic Services	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>	Patients	<u>0</u>
			Episodes of Care	<u>0</u>	Episodes of Care	<u>0</u>
Speech/Language Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Patients	<u>42</u>	Patients	<u>19</u>
			Episodes of Care	<u>34</u>	Episodes of Care	<u>34</u>
Therapeutic Recreational Service	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>	Patients	<u>0</u>
			Episodes of Care	<u>0</u>	Episodes of Care	<u>0</u>
Do you have a dedicated inpatient physical rehabilitation unit? <input type="radio"/> YES <input checked="" type="radio"/> NO						
If yes, please complete the following. Number of assigned beds <u>0</u> Number of admissions <u>0</u> Number of patient days <u>0</u>						
Do you have a dedicated outpatient physical rehabilitation unit? <input checked="" type="radio"/> YES <input type="radio"/> NO						
<b>H. Pain Management:</b>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>	Patients	<u>0</u>

SCHEDULE D - SERVICES (continued)\*

State ID 09245

Utilization of Selected Services	Is This Service Provided In Your Hospital?		To Inpatients		To Outpatients	
	YES	NO	Unit of Measure	Number	Unit of Measure	Number
<b>I. Obstetrics/Newborn:</b>						
<b>Obstetrics Level of Care</b>						
Level I	<input type="radio"/>	<input checked="" type="radio"/>				
Level II	<input type="radio"/>	<input checked="" type="radio"/>				
Level III	<input type="radio"/>	<input checked="" type="radio"/>				
Cesarean Section Deliveries	<input type="radio"/>	<input checked="" type="radio"/>	Deliveries	<u>0</u>		
Non C-Section Deliveries	<input type="radio"/>	<input checked="" type="radio"/>	Deliveries	<u>0</u>		
Birthing Rooms	<input type="radio"/>	<input checked="" type="radio"/>	Deliveries	<u>0</u>		
# rooms <u>0</u>						
# LDRP beds <u>0</u>						
# LDR beds <u>0</u>						
Labor Rooms	<input type="radio"/>	<input checked="" type="radio"/>				
# rooms <u>0</u>						
Postpartum Services	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>	Visits	<u>0</u>
# beds <u>0</u>						
Newborn Nursery	<input type="radio"/>	<input checked="" type="radio"/>	Infants Discharged	<u>0</u>		
# bassinets <u>0</u>			Patient Days	<u>0</u>		
Premature Nursery	<input type="radio"/>	<input checked="" type="radio"/>	Infants Discharged	<u>0</u>		
# bassinets <u>0</u>			Patient Days	<u>0</u>		
Isolation Nursery	<input type="radio"/>	<input checked="" type="radio"/>	Patient Days	<u>0</u>		
# bassinets <u>0</u>						

SCHEDULE D - SERVICES (continued)\*

State ID 09245

Utilization of Selected Services	Is This Service Provided In Your Hospital?		To Inpatients		To Outpatients	
	YES	NO	Unit of Measure	Number	Unit of Measure	Number
<b>J. Transplants:</b>						
<b>Organs</b>						
Total Donors			Donors	<u>0</u>		
Total Harvested	<input type="radio"/>	<input checked="" type="radio"/>	Donations	<u>0</u>		
Transplants	<input type="radio"/>	<input checked="" type="radio"/>	Transplants	<u>0</u>		
Organ Bank	<input type="radio"/>	<input checked="" type="radio"/>	Organs	<u>0</u>		
<b>Type of Organ:</b>						
Heart	<input type="radio"/>	<input checked="" type="radio"/>	# Harvested	<u>0</u>		
			# Transplanted	<u>0</u>		
Liver	<input type="radio"/>	<input checked="" type="radio"/>	# Harvested	<u>0</u>		
			# Transplanted	<u>0</u>		
Kidneys	<input type="radio"/>	<input checked="" type="radio"/>	# Harvested	<u>0</u>		
			# Transplanted	<u>0</u>		
Pancreas	<input type="radio"/>	<input checked="" type="radio"/>	# Harvested	<u>0</u>		
			# Transplanted	<u>0</u>		
Intestine	<input type="radio"/>	<input checked="" type="radio"/>	# Harvested	<u>0</u>		
			# Transplanted	<u>0</u>		
Any Other _____	<input type="radio"/>	<input checked="" type="radio"/>	# Harvested	<u>0</u>		
			# Transplanted	<u>0</u>		
<b>Tissues</b>						
Total Donors			Donors	<u>1</u>		
Total Harvested	<input checked="" type="radio"/>	<input type="radio"/>	Donations	<u>2</u>		
Transplants	<input type="radio"/>	<input checked="" type="radio"/>	Transplants	<u>0</u>		
Tissue Bank	<input type="radio"/>	<input checked="" type="radio"/>	Tissues	<u>0</u>		
<b>Type of Tissue:</b>						
Eye	<input checked="" type="radio"/>	<input type="radio"/>	# Harvested	<u>0</u>	# Transplanted	<u>0</u>
			# Transplanted	<u>0</u>		
Bone	<input checked="" type="radio"/>	<input type="radio"/>	# Harvested	<u>1</u>	# Transplanted	<u>0</u>
			# Transplanted	<u>0</u>		
Bone Marrow	<input checked="" type="radio"/>	<input type="radio"/>	# Harvested	<u>0</u>	# Transplanted	<u>0</u>
			# Transplanted	<u>0</u>		
Connective	<input checked="" type="radio"/>	<input type="radio"/>	# Harvested	<u>0</u>	# Transplanted	<u>0</u>
			# Transplanted	<u>0</u>		
Cardiovascular	<input checked="" type="radio"/>	<input type="radio"/>	# Harvested	<u>1</u>	# Transplanted	<u>0</u>
			# Transplanted	<u>0</u>		
Stem Cell	<input checked="" type="radio"/>	<input type="radio"/>	# Harvested	<u>0</u>	# Transplanted	<u>0</u>
			# Transplanted	<u>0</u>		
Other _____	<input checked="" type="radio"/>	<input type="radio"/>	# Harvested	<u>0</u>	# Transplanted	<u>0</u>
			# Transplanted	<u>0</u>		

SCHEDULE D - SERVICES (continued)\*

State ID 09245

Utilization of Selected Services	Is This Service Provided In Your Hospital?		To Inpatients		To Outpatients	
	YES	NO	Unit of Measure	Number	Unit of Measure	Number
<b>K. Other:</b>						
Hyperbaric Oxygen Therapy	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>		
Gamma Knife	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>	Patients	<u>0</u>
Cyberknife	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>	Patients	<u>0</u>
<b>L. Intensive/Intermediate:</b>						
Burn Care Unit # beds <u>0</u>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>	Patients	<u>0</u>
			Patient Days	<u>0</u>		
Cardiac Care Unit # beds <u>0</u>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>		
			Patient Days	<u>0</u>		
Medical Intensive Care Unit # beds <u>0</u>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>		
			Patient Days	<u>0</u>		
Mixed Intensive Care Unit # beds <u>6</u>	<input checked="" type="radio"/>	<input type="radio"/>	Patients	<u>105</u>		
			Patient Days	<u>147</u>		
<b>Neonatal Level of Care</b> (Indicate highest level of care.)						
Level I # beds <u>0</u>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>		
			Patient Days	<u>0</u>		
Level II A # beds <u>0</u>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>		
			Patient Days	<u>0</u>		
Level II B # beds <u>0</u>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>		
			Patient Days	<u>0</u>		
Level III A # beds <u>0</u>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>		
			Patient Days	<u>0</u>		
Level III B # beds <u>0</u>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>		
			Patient Days	<u>0</u>		
Level III C # beds <u>0</u>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>		
			Patient Days	<u>0</u>		
Pediatric Care Unit # beds <u>0</u>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>		
			Patient Days	<u>0</u>		
Stepdown ICU # beds <u>0</u>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>		
			Patient Days	<u>0</u>		
Stepdown CCU # beds <u>0</u>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>		
			Patient Days	<u>0</u>		
Surgical Intensive Care Unit # beds <u>0</u>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>		
			Patient Days	<u>0</u>		



SCHEDULE D - SERVICES (continued)\*

State ID 09245

Utilization of Selected Services	Is This Service Provided In Your Hospital?		To Inpatients		To Outpatients	
	YES	NO	Unit of Measure	Number	Unit of Measure	Number
<b>L. Intensive/Intermediate (continued):</b>						
Other, specify <u>Swing Bed</u>	<input checked="" type="radio"/>	<input type="radio"/>	Patients	<u>0</u>		
Number of beds <u>15</u>			Patient Days	<u>0</u>		
Other, specify _____	<input type="radio"/>	<input type="radio"/>	Patients	<u>0</u>		
Number of beds <u>0</u>			Patient Days	<u>0</u>		
<b>M. Psychiatric Partial Hospitalization</b>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>		
<b>N. Psychiatric Intensive Outpatient Care</b>	<input type="radio"/>	<input checked="" type="radio"/>			Patients	<u>0</u>
<b>O. Electroconvulsive Treatment</b>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>	Patients	<u>0</u>
			Treatments	<u>0</u>	Treatments	<u>0</u>
<b>P. Other Convulsive Treatment</b>	<input type="radio"/>	<input checked="" type="radio"/>	Patients	<u>0</u>	Patients	<u>0</u>
			Treatments	<u>0</u>	Treatments	<u>0</u>
<b>Q. Negative Pressure Ventilated Room</b>	<input checked="" type="radio"/>	<input type="radio"/>				
If yes, number of beds <u>2</u>						
<b>R. 23 Hour Observation</b>	<input checked="" type="radio"/> YES	<input type="radio"/> NO	Outpatients	<u>535</u>		
<b>S. Cancer Patients:</b>						
1. How many patients were diagnosed with cancer at your facility during this reporting period?				<u>12</u>		
2. How many patients were both diagnosed and provided the first course of treatment for cancer at your facility during this reporting period?						<u>12</u>
3. How many patients were diagnosed elsewhere but provided the first course of treatment at your facility during this reporting period?						<u>0</u>

**SCHEDULE E - FINANCIAL DATA\***

State ID 09245

Dates covered from 10/01/2012 to 09/30/2013 Use zeros where applicable. Do not leave blank lines in this schedule.

A. CHARGES (For reporting period only. Do not include revenue related losses; round to the nearest dollar.)

	Gross Patient Charges	minus	Adjustments To Charges	equals	Net Patient Revenue
<b>1. Government</b>					
a) Medicare Inpatient - Total (include managed care)	\$7,577,827	-	\$4,879,515	=	\$2,698,312
1) Medicare Managed Care - Inpatient	\$982,543	-	\$643,153	=	\$339,390
b) Medicare Outpatient - Total (include managed care)	\$16,813,308	-	\$13,936,709	=	\$2,876,599
1) Medicare Managed Care - Outpatient	\$2,647,761	-	\$2,177,819	=	\$469,941
c) Medicaid/TennCare Inpatient* (for EAH use 7.b.2.)	\$474,220	-	\$370,526	=	\$103,694
d) Medicaid/TennCare Outpatient* (for EAH use 7.b.2.)	\$6,041,021	-	\$4,835,839	=	\$1,205,182
e) Other	\$0	-	\$0	=	\$0
f) Total Government Sources	\$30,906,376	-	\$24,022,589	=	\$6,883,787
<b>2. Cover Tennessee</b> * see instructions					
a) Cover TN	\$240,739	-	\$202,656	=	\$38,083
b) Cover Kids	\$31,860	-	\$12,751	=	\$19,109
c) Access Tennessee	\$0	-	\$0	=	\$0
d) Total Cover Tennessee	\$272,599	-	\$215,407	=	\$57,192
<b>3. Nongovernment</b>					
a) Self-Pay	\$4,554,205	-	\$4,554,205	=	\$0
b) Blue Cross Blue Shield	\$3,779,787	-	\$2,167,555	=	\$1,612,232
c) Commercial Insurers (excludes Workers Comp)	\$3,980,543	-	\$1,251,601	=	\$2,728,942
d) Workers Compensation	\$0	-	\$0	=	\$0
e) Other	\$1,752	-	\$0	=	\$1,752
f) Total Nongovernment Sources	\$12,316,287	-	\$7,973,361	=	\$4,342,926
<b>4. Totals</b>					
a) Total Inpatient (excludes Newborn)	\$9,447,021				
b) Newborns	\$0				
c) Total Inpatient (includes Newborn) (A4a + A4b)	\$9,447,021	-	\$6,694,319	=	\$2,752,702
d) Total Outpatient	\$34,048,241	-	\$25,517,038	=	\$8,531,203
e) Grand Total (A1f + A2d + A3f)	\$43,495,262	-	\$32,211,357	=	\$11,283,905
<b>5. Bad Debt</b>					
a) Medicare Enrollees			\$0		
b) Other Government			\$0		
c) Cover Tennessee			\$0		
d) Blue Cross and Commercially Insured Patients			\$0		
e) All Other			\$2,677,554		
f) Total Bad Debt			\$2,677,554		
<b>6. Nongovernment and Cover Tennessee Adjustments to Charges</b>					
a) Nongovernment Contractual			\$3,360,512	Amount of discounts provided	
b) Cover Tennessee Contractual			\$215,407	to uninsured patients	\$1,193,550
c) Charity Care - Inpatient			\$139,082		
d) Charity Care - Outpatient			\$373,790	\$512,872	\$3,190,426
e) Other Adjustments, specify types W/C, Administrative,			\$1,422,423	Total Charity	Total Charity plus Bad Debt
f) Total Nongovernment Adjustments			\$5,511,214	(A6c + A6d)	(A5f + A6c + A6d)

## SCHEDULE E - FINANCIAL DATA (continued)\*

State ID 09245

## A. CHARGES (continued)

## 7. Other Operating Revenue

a) Tax appropriations	\$0
b) State and Local government contributions:	
1) Amount designated to offset indigent care	\$111,215
2) Essential Access Hospital (EAH) payments	\$211,304
3) Critical Access Hospital (CAH) payments	\$0
4) Amount used for other	\$0
5) Total	\$322,519
c) Other contributions:	
1) Amount designated to offset indigent care	\$0
2) Amount used for other	\$0
3) Total	\$0
d) Other (include cafeteria, gift shop, etc.)	\$238,085
e) Total other operating revenue	\$560,604
(A7a + A7b5 + A7c3 + A7d)	

## 8. Nonoperating Revenue (No negative numbers! Losses or expenses should be reported in B2g.)

a) Contributions	\$0
b) Grants	\$50,048
c) Interest Income	\$4,014
d) Other	\$0
e) Total nonoperating revenue	\$54,062
(add A8a through A8d)	
f) TOTAL REVENUE	\$11,898,571
(Net A4e + A7e + A8e)	

## B. EXPENSES (for the reporting period only; round to the nearest dollar)

## 1. Payroll Expenses for all categories of personnel specified below; (see definitions page)

a) Physicians and dentists (include only salaries)	\$0
b) Medical and dental residents (include medical and dental interns)	\$0
c) Trainees (medical technology, x-ray therapy, administrative, and so forth)	\$0
d) Registered and licensed practical nurses	\$2,116,829
e) All other personnel	\$4,158,898
f) Total payroll expenses	\$6,275,727
(add B1a through B1e)	

## 2. Nonpayroll Expenses

a) Employee benefits (social security, group insurance, retirement benefits)	\$2,157,902
b) Professional fees (medical, dental, legal, auditing, consultant and so forth)	\$808,112
c) Contracted nursing services (include staff from nursing registries, service contracts, and temporary help agencies)	\$0
d) Depreciation expense	\$1,054,295
e) Interest expense	\$22,967
f) Energy expense	\$433,999
g) All other expenses (supplies, purchased services, nonoperating expenses, and so forth)	\$5,218,507
h) Total nonpayroll expenses (add B2a through B2g)	\$9,695,782
i) TOTAL EXPENSES (add B1f + B2h)	\$15,971,509

## 3. Are system overhead/management fees included in your expenses?

☒ YES    ☐ NO

If yes, specify amount \$1,932,024

**C. CURRENT ASSETS**

1. Current Assets is defined as the value of cash, accounts receivable, inventories, marketable securities and other assets that could be converted to cash in less than 1 year.

What were your current assets on the last day of your reporting period (specified in Schedule A7 on page 2)? \$2,555,159

Net receivables are defined as the collectibles as of the last day of your reporting period, whether or not they are currently due.

2. What were your net receivables on the last day of your reporting period? \$1,272,519

**D. FIXED ASSETS** recorded on the balance sheet at the end of the reporting period (include actual or estimated value of plant/equipment that is leased).

- |  |                     |
|--|---------------------|
| 1. Gross plant and equipment assets (including land, building, and equipment)                      | <u>\$22,763,919</u> |
| 2. LESS: Deduction for accumulated depreciation  | <u>\$15,361,100</u> |
| 3. NET FIXED plant and equipment assets (D.1. Less D.2.; if zero please explain on separate sheet) | <u>\$7,402,819</u>  |

**E. OTHER ASSETS** recorded on the balance sheet at the end of the reporting period (include assets not included above as current or fixed assets).

What were your other assets on the last day of your reporting period (specified in Schedule A7 on page 2)? \$5,287

**F. TOTAL ASSETS**

Total Assets is the sum of current assets, fixed assets and other assets (C.1.+D.3.+E.).

What were your total assets on the last day of your reporting period (specified in Schedule A7 on page 2)? \$9,963,265

**G. CURRENT LIABILITIES**

Current liabilities is defined as the amount owed for salaries, interest, accounts payable, and other debts due within one (1) year. What were your current liabilities on the last day of your reporting period? \$20,603,436

**H. LONG TERM LIABILITIES**

1. Long Term Liabilities is defined as the amount owed for leases, bond repayment and other items due after one (1) year. What were your long term liabilities on the last day of your reporting period? \$409,314

2. Long Term Debt is defined as the value of obligations of over 1 year that require interest to be paid. What was your long term debt on the last day of your reporting period? \$0

**I. OTHER LIABILITIES**

Other liabilities includes those liabilities not reported as current (item G.) or long term (item H.1.).

What were your total liabilities on the last day of your reporting period (specified in Schedule A7 on page 2)? \$0

**J. CAPITAL ACCOUNT**

Capital Account includes Fund Balance or Stockholder's Equity and all general, specific purpose, restricted or unrestricted funds. The Capital Account is the excess of assets over its liabilities.

What was your capital account on the last day of your reporting period? \$11,049,484

Note: Total Assets should equal Liabilities plus Capital Account (i.e. item F.=G.+H.1.+I.+J.).

**K. 1. Federal Income Tax:**

\$0

**2. Local Property Taxes Paid During the Reporting Period:**

a) Taxes on the Inpatient Facility \$46,220

b) Taxes on all Other Property \$0

**3. Other Local, State, or Federal Taxes:**

(exclude sales tax)

\$94

**L. Does your hospital bill include charges incurred for the following professional services?**

Radiology - ☐ YES ☒ NO Pathology - ☐ YES ☒ NO Anesthesiology - ☐ YES ☒ NO Other - Specify EEG

## SCHEDULE E - FINANCIAL DATA (continued)\*

State ID 09245

## M. TennCare Utilization and Revenue:

## 1. Inpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF ADMISSIONS	NUMBER OF PATIENT DAYS	GROSS REVENUE	NET REVENUE
United Health Care Community Plan	23	62	\$253,009	\$80,489
Amerigroup	0	0	\$0	\$0
Blue Care	14	47	\$170,390	\$72,575
TennCare Select	1	2	\$4,796	\$1,144
TennCare, MCO (Not Specified)	0	0	\$0	\$0
Total MCO	38	111	\$428,195	\$154,208

## 2. Outpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF PATIENTS	NUMBER OF VISITS	GROSS REVENUE	NET REVENUE
United Health Care Community Plan	1,789	1,789	\$2,995,763	\$598,435
Amerigroup	0	0	\$0	\$0
Blue Care	2,164	2,164	\$3,519,766	\$746,077
TennCare Select	93	93	\$170,824	\$28,192
TennCare, MCO (Not Specified)	2	2	\$2,014	\$1,030
Total MCO	4,048	4,048	\$6,688,367	\$1,373,734

SCHEDULE F - BEDS AND BASSINETS\*

State ID 09245

1. PLEASE GIVE THE NUMBER OF:

A. TOTAL LICENSED ADULT AND PEDIATRIC BEDS AS OF THE LAST DAY OF THE REPORTING PERIOD

(exclude beds in a sub-acute unit that are licensed as nursing home beds) 70

B. The number of adult and pediatric staffed beds set up, staffed and in use as of the last day of the reporting period. 33

C. NEWBORN NURSERY BASSINETS AS OF THE LAST DAY OF THE REPORTING PERIOD 0

D. Licensed Beds that were not staffed at any time during the reporting period. 0

2. STAFFED ADULT, PEDIATRIC, AND NEONATAL BEDS (exclude newborn nursery, include neonatal care units):

Was there a temporary or a permanent change in the total number of beds set up and staffed during the period? ☐ YES ☒ NO

If yes, give beds added or withdrawn (show increase by + and decrease by -) and date of change.

Bed change (+ or -) 0    Bed change (+ or -) 0    Bed change (+ or -) 0    Bed change (+ or -) 0

Date: \_\_\_\_\_    Date: \_\_\_\_\_    Date: \_\_\_\_\_    Date: \_\_\_\_\_

3 SWING BEDS:

A. Does your facility utilize swing beds? ☒ YES ☐ NO    If yes, number of Acute Care beds designated as Swing Beds. 15

B. PLEASE SPECIFY THE FOLLOWING FOR BEDS WHEN USED FOR LONG TERM SKILLED OR INTERMEDIATE CARE:

(How many admissions and how many days did you provide in the following categories?)

INTERMEDIATE CARE	ADMISSIONS	PATIENT DAYS
Private Pay	0	0
Other	0	0
Total	0	0

SKILLED CARE	ADMISSIONS	PATIENT DAYS
Commercial	4	34
Blue Cross	0	0
Medicare	135	1,292
Private Pay	1	6
Other	0	0
Total	140	1,332

## SCHEDULE F - BEDS AND BASSINETS (continued)\*

State ID 09245

## 4. A. Number of Beds Set Up and Staffed on a typical day

SERVICE	BEDS
Medical	0
Surgical	0
Medical/Surgical	32
Obstetrics	0
Gynecological	0
OB/GYN	0
Pediatric	0
Eye	0
Neonatal Care	0
Intensive Care (excluding Neonatal)	1
Orthopedic	0
Urology	0
Rehabilitation	0
Chronic/Extended Care	0
Pulmonary	0
Psychiatric	0
Psychiatric specifically for Children and Youth under age 18	0
Psychiatric specifically for Geriatric Patients	0
Chemical Dependency	0
Chemical Dependency specifically for Children and Youth under age 18	0
Chemical Dependency specifically for Geriatric Patients	0
Swing Beds (for long term skilled or intermediate care)	0
Other, specify	0
Unassigned	0
TOTAL	33

B. Number of Patients in hospital on a typical day. Exclude normal newborns (See Instructions),  
long term skilled or intermediate patients. 10

## 5. OBSERVATION BEDS

A. Do you use inpatient staffed beds for 23-hour observation? ☒ YES ☐ NO If yes, number of beds 15

B. Do you have beds assigned to dedicated 23-hour observation unit? ☐ YES ☒ NO If yes, number of beds 0

C. Do you have beds in a "same-day-surgery" unit that are used for both same-day surgery and 23-hour observation? ☐ YES ☒ NO  
If yes, number of beds 0

## SCHEDULE G - UTILIZATION\*

State ID 09245

## 1. INPATIENT UTILIZATION (include normal newborns)

Patient Census Records:

Please indicate whether you are reporting Admissions and Inpatient Days ☐  
 or Discharges and Discharge Patient Days ☒

## 2. UTILIZATION BY MAJOR DIAGNOSTIC CATEGORIES:

MAJOR DIAGNOSTIC CATEGORIES	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS
01 Nervous System	56	191
02 Eye	1	3
03 Ear, Nose, Mouth and Throat	1	3
04 Respiratory System	123	413
05 Circulatory System	69	204
06 Digestive System	61	213
07 Hepatobiliary System & Pancreas	15	48
08 Musculoskeletal Sys. & Connective Tissue	6	45
09 Skin, Subcutaneous Tissue & Breast	22	85
10 Endocrine, Nutritional & Metabolic	27	71
11 Kidney & Urinary Tract	52	161
12 Male Reproductive System	0	0
13 Female Reproductive System	9	22
14 Pregnancy, Childbirth & the Puerperium	1	2
15 Normal Newborns & Other Neonates with Conditions Originating in the Perinatal Period	0	0
16 Blood and Blood Forming Organs and Immunological Disorders	11	28
17 Myeloproliferative Disorders & Poorly Differentiated Neoplasms	0	0
18 Infectious & Parasitic Diseases	51	160
19 Mental Diseases & Disorders	0	0
20 Alcohol/Drug Use & Alcohol/Drug-Induced Organic Mental Disorders	0	0
21 Injuries, Poisoning, & Toxic Effects of Drugs	5	12
22 Burns	0	0
23 Factors Influencing Health Status and Other Contacts with Health Services	118	1,239
24 Multiple Significant Trauma	1	6
25 Human Immunodeficiency Virus Infections	0	0
26 Other DRGs Associated with All MDCs	0	0
TOTAL	629	2,906



SCHEDULE G - UTILIZATION (continued)\*

State ID 09245

3. UTILIZATION BY REVENUE SOURCE (excluding normal newborns -- see Instructions)

Patients should be categorized according to primary payer and counted only once.

Please indicate whether you are reporting Admissions and Inpatient Days ☒ or Discharges and Discharge Patient Days ☐

	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS	OUTPATIENT VISITS*
a) Self Pay	33	116	2,062
b) Blue Cross/Blue Shield	27	68	2,174
c) Champus/TRICARE	6	13	232
d) Commercial Insurance (excludes Workers Comp)	23	60	309
e) Cover TN	0	0	89
f) Cover Kids	0	0	42
g) Access TN	0	0	3
h) Medicaid/TennCare	35	100	4,169
i) Medicare - Total	363	1,204	6,796
Medicare Managed Care	0	0	0
j) Workers Compensation	0	0	191
k) Other	0	0	1,196
l) Total	487	1,561	17,263

\* Should include emergency department visits and hospital outpatient visits

4. NUMBER OF PATIENTS BY AGE GROUP (excluding normal newborns -- see Instructions)

Please indicate whether you are reporting Admissions and Inpatient Days ☐ or Discharges and Discharge Patient Days ☒

Age	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS	OUTPATIENT VISITS*
Under 15 years	6	13	1,522
15-17 years	0	0	488
18-64 years	192	659	10,180
65-74 years	141	690	2,570
75-84 years	161	798	1,786
85 years & older	129	746	717
GRAND TOTAL	629	2,906	17,263

\* Should include emergency department visits and hospital outpatient visits

## SCHEDULE G - UTILIZATION (continued)\*

State ID 09245

## 5. PATIENT ORIGIN (excluding normal newborns -- see Instructions)

Indicate usual residence of patients and number of patient days. Please indicate whether you are reporting

Admissions and Inpatient Days ☐ or Discharges and Discharge Patient Days ☒

\*\* List only those counties in other states that represent at least 1 percent of the total admissions or discharges to your hospital.

If you have fewer than 500 total discharges or admissions annually, list only those counties that represent at least 2 percent of your total admissions or discharges.

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
01	Anderson	0	0
02	Bedford	0	0
03	Benton	38	144
04	Bledsoe	0	0
05	Blount	0	0
06	Bradley	0	0
07	Campbell	0	0
08	Cannon	0	0
09	Carroll	525	2,439
10	Carter	0	0
11	Cheatham	0	0
12	Chester	0	0
13	Claiborne	0	0
14	Clay	0	0
15	Cocke	0	0
16	Coffee	0	0
17	Crockett	0	0
18	Cumberland	0	0
19	Davidson	0	0
20	Decatur	0	0
21	DeKalb	0	0
22	Dickson	3	11
23	Dyer	0	0
24	Fayette	0	0
25	Fentress	0	0
26	Franklin	0	0
27	Gibson	2	6
28	Giles	0	0

## 5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
29	Grainger	0	0
30	Greene	0	0
31	Grundy	0	0
32	Hamblen	0	0
33	Hamilton	0	0
34	Hancock	0	0
35	Hardeman	0	0
36	Hardin	0	0
37	Hawkins	0	0
38	Haywood	0	0
39	Henderson	10	60
40	Henry	6	19
41	Hickman	0	0
42	Houston	0	0
43	Humphreys	0	0
44	Jackson	0	0
45	Jefferson	0	0
46	Johnson	0	0
47	Knox	0	0
48	Lake	0	0
49	Lauderdale	0	0
50	Lawrence	0	0
51	Lewis	0	0
52	Lincoln	0	0
53	Loudon	0	0
54	McMinn	0	0
55	McNairy	0	0
56	Macon	0	0
57	Madison	3	8
58	Marion	0	0
59	Marshall	0	0
60	Maury	0	0
61	Meigs	0	0
62	Monroe	0	0

## 5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
63	Montgomery	0	0
64	Moore	0	0
65	Morgan	0	0
66	Obion	0	0
67	Overton	0	0
68	Perry	0	0
69	Pickett	0	0
70	Polk	0	0
71	Putnam	0	0
72	Rhea	0	0
73	Roane	0	0
74	Robertson	0	0
75	Rutherford	0	0
76	Scott	0	0
77	Sequatchie	0	0
78	Sevier	0	0
79	Shelby	0	0
80	Smith	0	0
81	Stewart	0	0
82	Sullivan	0	0
83	Sumner	0	0
84	Tipton	0	0
85	Trousdale	0	0
86	Unicoi	0	0
87	Union	0	0
88	Van Buren	0	0
89	Warren	0	0
90	Washington	0	0
91	Wayne	0	0
92	Weakley	18	79
93	White	0	0
94	Williamson	0	0
95	Wilson	0	0
96	TN County Unknown	23	139
	<b>Tennessee Total</b>	<b>628</b>	<b>2,905</b>

## 5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
ALABAMA COUNTIES: (Specify)		
1) _____	0	0
2) _____	0	0
Other Alabama Counties	0	0
<i>Alabama Total</i>	0	0
GEORGIA COUNTIES: (Specify)		
1) _____	0	0
2) _____	0	0
Other Georgia Counties	0	0
<i>Georgia Total</i>	0	0
MISSISSIPPI COUNTIES: (Specify)		
1) _____	0	0
2) _____	0	0
Other Mississippi Counties	0	0
<i>Mississippi Total</i>	0	0
ARKANSAS COUNTIES: (Specify)		
1) _____	0	0
2) _____	0	0
Other Arkansas Counties	0	0
<i>Arkansas Total</i>	0	0
MISSOURI COUNTIES: (Specify)		
1) _____	0	0
2) _____	0	0
Other Missouri Counties	0	0
<i>Missouri Total</i>	0	0

## 5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
KENTUCKY COUNTIES: (Specify)		
1) _____	0	0
2) _____	0	0
Other Kentucky Counties	0	0
<i>Kentucky Total</i>	0	0
VIRGINIA COUNTIES: (Specify)		
1) _____	0	0
2) _____	0	0
Other Virginia Counties	0	0
<i>Virginia Total</i>	0	0
NORTH CAROLINA COUNTIES: (Specify)		
1) _____	0	0
2) _____	0	0
Other North Carolina Counties	0	0
<i>North Carolina Total</i>	0	0
OTHER STATES: (Specify)		
1) Illinois	1	1
2) _____	0	0
All Other States and Countries	0	0
RESIDENCE UNKNOWN:		
	0	0
<b>GRAND TOTAL</b>	629	2,906

SCHEDULE G - UTILIZATION (continued)\*

State ID 09245

6. Delivery Status:

A. Number of Infants Born Alive 0

B. Number of Deaths Among Infants Born Alive 0

C. Number of Fetal Deaths (350 grams or 20 weeks or more gestation) 0

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS\*

State ID 09245

1. TYPE OF UNIT - PSYCHIATRIC:

- A. Do you have a dedicated psychiatric unit? ☐ YES ☒ NO If yes, please complete items on this page and on the next page.  
 B. Do you have a designated Gero-Psychiatric Unit? ☐ YES ☒ NO

2. BEDS

- A. Number of assigned beds 0  
 B. Date unit opened \_\_\_\_\_

3. UTILIZATION BY AGE GROUPS:

Please indicate if you are reporting Admissions and Inpatient Days ☒ or Discharges and Discharge Patient Days. ☐

AGE GROUPS	Inpatient			Partial Care or Day Hospital	Outpatient
	Number of Patients on September 30	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Visits
Children and/or Adolescents Ages 0 - 17	0	0	0	0	0
Adults Ages 18 - 64	0	0	0	0	0
Elderly Ages 65 and older	0	0	0	0	0
Total	0	0	0	0	0

4. Is the psychiatric service managed under a management contract different from the hospital itself? ☐ YES ☒ NO

If yes, please specify name of organization that manages the unit. \_\_\_\_\_

5. Do you have contracts with Behavioral Health Organizations? ☒ YES ☐ NO

6. Does your hospital use:

If Yes,

- A. Seclusion ☒ YES ☐ NO  
 B. Mechanical Restraints ☒ YES ☐ NO  
 C. Physical Holding Restraints ☒ YES ☐ NO  
 D. Chemical Restraints ☒ YES ☐ NO

Number of Patients Secluded or Restrained		Number of Times Seclusion or Restraint was Initiated	
Age 0-17	Age 18+	Age 0-17	Age 18+
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0



## SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS (continued)\*

State ID 09245

## 7. FINANCIAL DATA - PSYCHIATRIC

	INPATIENT CHARGES	plus	OUTPATIENT CHARGES	equals	TOTAL CHARGES	minus	ADJUSTMENTS TO CHARGES	equals	NET PATIENT REVENUE
<b>A. GROSS PATIENT REVENUE &amp; NET PATIENT REVENUE BY PAYER:</b>									
1. Self Pay	\$0	+	\$0	=	\$0	-	\$0	=	\$0
2. Blue Cross/Blue Shield	\$0	+	\$0	=	\$0	-	\$0	=	\$0
3. Champus/TRICARE	\$0	+	\$0	=	\$0	-	\$0	=	\$0
4. Commercial Insurance (excludes Workers Comp)	\$0	+	\$0	=	\$0	-	\$0	=	\$0
5. Cover TN	\$0	+	\$0	=	\$0	-	\$0	=	\$0
6. Cover Kids	\$0	+	\$0	=	\$0	-	\$0	=	\$0
7. Access TN	\$0	+	\$0	=	\$0	-	\$0	=	\$0
8. Medicaid/TennCare	\$0	+	\$0	=	\$0	-	\$0	=	\$0
9. Medicare - Total	\$0	+	\$0	=	\$0	-	\$0	=	\$0
Medicare Managed Care	\$0	+	\$0	=	\$0	-	\$0	=	\$0
10. Workers Compensation	\$0	+	\$0	=	\$0	-	\$0	=	\$0
11. Other	\$0	+	\$0	=	\$0	-	\$0	=	\$0
<b>B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE</b>									
1. Bad Debt							\$0		
2. Charity Care							\$0		
3. Contractual Adjustments							\$0		
4. Total							\$0		
5. Amount of discounts provided to uninsured patients							\$0		
<b>8. A. SERVICE CHARGES</b>									
	INPATIENT CHARGES		OUTPATIENT CHARGES						
1. Routine Treatment	\$0		\$0						
2. Ancillary Services	\$0		\$0						
3. Other	\$0		\$0						
4. Total	\$0		\$0						
<b>B. Do these charges include physicians' fees?</b>									
	<input type="radio"/> YES <input checked="" type="radio"/> NO								

## 1. TYPE OF UNIT - CHEMICAL DEPENDENCY:

Do you have a dedicated chemical dependency unit? ☐ YES ☒ NO If yes, please complete items on this page and on the next page.

## 2. BEDS

A. Number of assigned beds 0

B. Date unit opened \_\_\_\_\_

## 3. UTILIZATION BY AGE GROUPS:

Please indicate if you are reporting Admissions and Inpatient Days ☒ or Discharges and Discharge Patient Days. ☐

AGE GROUPS	Inpatient			Partial Care or Day Hospital	Outpatient	Residential Care
	Number of Patients on September 30	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Visits	Number of Visits
Children and/or Adolescents Ages 0 - 17	0	0	0	0	0	0
Adults Ages 18 - 64	0	0	0	0	0	0
Elderly Ages 65 and older	0	0	0	0	0	0
Total	0	0	0	0	0	0

4. Is the chemical dependency service managed under a management contract different from the hospital itself? ☐ YES ☒ NO

If yes, please specify name of organization that manages the unit. \_\_\_\_\_

5. Do you have contracts with Behavioral Health Organizations? ☐ YES ☒ NO

## 6. FINANCIAL DATA - CHEMICAL DEPENDENCY

	INPATIENT CHARGES	plus	OUTPATIENT CHARGES	equals	TOTAL CHARGES	minus	ADJUSTMENTS TO CHARGES	equals	NET PATIENT REVENUE
<b>A. GROSS PATIENT REVENUE &amp; NET PATIENT REVENUE BY PAYER:</b>									
1. Self Pay	\$0	+	\$0	=	\$0	-	\$0	=	\$0
2. Blue Cross/Blue Shield	\$0	+	\$0	=	\$0	-	\$0	=	\$0
3. Champus/TRICARE	\$0	+	\$0	=	\$0	-	\$0	=	\$0
4. Commercial Insurance (excludes Workers Comp)	\$0	+	\$0	=	\$0	-	\$0	=	\$0
5. Cover TN	\$0	+	\$0	=	\$0	-	\$0	=	\$0
6. Cover Kids	\$0	+	\$0	=	\$0	-	\$0	=	\$0
7. Access TN	\$0	+	\$0	=	\$0	-	\$0	=	\$0
8. Medicaid/TennCare	\$0	+	\$0	=	\$0	-	\$0	=	\$0
9. Medicare - Total	\$0	+	\$0	=	\$0	-	\$0	=	\$0
Medicare Managed Care	\$0	+	\$0	=	\$0	-	\$0	=	\$0
10. Workers Compensation	\$0	+	\$0	=	\$0	-	\$0	=	\$0
11. Other	\$0	+	\$0	=	\$0	-	\$0	=	\$0

**B. NON-GOVERNMENT ADJUSTMENTS  
TO REVENUE**

1. Bad Debt	\$0
2. Charity Care	\$0
3. Contractual Adjustments	\$0
4. Total	\$0
5. Amount of discounts provided to uninsured patients	\$0

## 7. A. SERVICE CHARGES

	INPATIENT CHARGES	OUTPATIENT CHARGES
1. Routine Treatment	\$0	\$0
2. Ancillary Services	\$0	\$0
3. Other	\$0	\$0
4. Total	\$0	\$0

B. Do these charges include physicians' fees?

☐ YES☒ NO

SCHEDULE I - EMERGENCY DEPARTMENT\*

State ID 09245

1. What is the direct telephone number into your Emergency Department? (731) 986-7360

2. Is the Emergency Department managed under a management contract different from the hospital itself? ☐ YES ☒ NO

If yes, with whom is the contract held? \_\_\_\_\_

3. Emergency Department:

Number of visits by payer:

A. Self Pay	<u>1,452</u>	H. Medicaid/Tenncare		L. Grand Total	<u>7,463</u>
B. Blue Cross/Blue Shield	<u>630</u>	United Health Care Community Plan	<u>0</u>		
C. Champus/TRICARE	<u>93</u>	Amerigroup	<u>5</u>		
D. Commercial Insurance (excludes Workers Comp)	<u>414</u>	Blue Care	<u>1,212</u>		
E. Cover TN	<u>61</u>	TennCare Select	<u>0</u>		
F. Cover Kids	<u>10</u>	TennCare, MCO (Not Specified)	<u>951</u>		
G. Access TN	<u>0</u>	TennCare Total	<u>2,169</u>		
		I. Medicare - Total	<u>2,545</u>		
		Medicare Managed Care	<u>0</u>		
		J. Workers Compensation	<u>89</u>		
		K. Other	<u>0</u>		

4. Is your Emergency Department staffed 24 hours per day? ☒ YES ☐ NO If no, please give hours covered. 0

SCHEDULE I - EMERGENCY DEPARTMENT (continued)\*

State ID 09245

5. Indicate the number of the following personnel available in the hospital on a normal day and how many are available to the Emergency Department.

	ON HOSPITAL CAMPUS	IN EMERGENCY DEPARTMENT
A. PHYSICIANS:		
Board certified in Emergency Medicine	<u>0</u>	<u>0</u>
Board eligible in Emergency Medicine	<u>0</u>	<u>0</u>
Declared Speciality of Emergency Medicine	<u>0</u>	<u>0</u>
Board Certified Psychiatrists	<u>0</u>	<u>0</u>
Other Physicians Available to Emergency Department	<u>4</u>	<u>1</u>
B. NURSES:		
Nurse Practitioners	<u>3</u>	<u>0</u>
R.N.'s with formal emergency training and experience	<u>0</u>	<u>0</u>
Other R.N.'s	<u>16</u>	<u>3</u>
L.P.N.'s and other nursing support personnel	<u>4</u>	<u>2</u>
Clerical Staff	<u>16</u>	<u>2</u>
C. OTHER:		
E.M.T.	<u>0</u>	<u>0</u>
E.M.T. advanced	<u>4</u>	<u>0</u>

SCHEDULE I - EMERGENCY DEPARTMENT (continued)\*

State ID 09245

6. SUPPORTIVE SERVICES:

YES NO

A. COMMUNICATIONS:

Two-Way radio in ER with Access to:

Central Emergency Dispatch Center

☒ ☐

Ambulances

☒ ☐

Other hospitals

☒ ☐

B. HELIPORT:

☒ ☐

C. PHARMACY IN ER:

☒ ☐

D. BLOOD BANK (check ONLY one):

Fully stocked

☐

Common blood types only

☒

7. Do you have dedicated centers for the provision of specialized emergency care for the following:

A. Designated Trauma Center

☐ YES ☒ NO

B. Burns

☐ YES ☒ NO

If yes, do you have a designation by a government agency as a Burn Center? ☐ YES ☒ NO

C. Pediatrics

☐ YES ☒ NO

D. Other, specify

\_\_\_\_\_

8. Triage: A. Total number of patients who presented in your ER. 7,636

B. Total number treated in your ER. 7,452

C. Total number not treated in your ER but referred to physician or clinic for treatment. 0

SCHEDULE J - PERSONNEL ON PAYROLL AS OF LAST DAY OF REPORTING PERIOD AND USE OF CONTRACT EMPLOYEES\*

State ID 09245

	Full-Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***		Full-Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***
1. Administration:				12. Radiological services:			
A. Administrators & Assistants . . . .	0.0	0.0	<input type="checkbox"/>	A. Radiographers (radiologic technologists) . . . . .	6.0	0.0	<input type="checkbox"/>
B. Director, Health Services Research & Assistants . . . . .	0.0	0.0	<input type="checkbox"/>	B. Radiation therapy technologists . . . .	0.0	0.0	<input type="checkbox"/>
C. Marketing & Planning Officer(s) & Assistants . . . . .	0.0	0.0	<input type="checkbox"/>	C. Nuclear medicine technologists . . . .	0.0	0.0	<input type="checkbox"/>
D. Financial and Accounting Officer(s) & Assistants . . . . .	1.0	0.0	<input type="checkbox"/>	D. Other radiologic personnel . . . . .	3.8	0.0	<input type="checkbox"/>
2. Physician and Dental Services:				13. Therapeutic services:			
A. Physicians . . . . .	0.0	0.0	<input type="checkbox"/>	A. Occupational therapists . . . . .	0.0	0.0	<input type="checkbox"/>
B. Medical residents . . . . .	0.0	0.0	<input type="checkbox"/>	B. Occupational therapy assistants & aides . . . . .	0.0	0.0	<input type="checkbox"/>
C. Dentists . . . . .	0.0	0.0	<input type="checkbox"/>	C. Physical therapists . . . . .	1.0	0.2	<input type="checkbox"/>
D. Dental residents . . . . .	0.0	0.0	<input type="checkbox"/>	D. Physical therapy assistants & aides . .	4.0	0.0	<input type="checkbox"/>
3. Nursing Services:				E. Recreational therapists . . . . .	0.0	0.0	<input type="checkbox"/>
A. RNs - Administrative . . . . .	2.5	0.0	<input type="checkbox"/>	14. Speech and hearing services:			
B. RNs - Patient care/clinical . . . . .	26.2	1.0	<input type="checkbox"/>	A. Speech Pathologist . . . . .	0.1	0.0	<input type="checkbox"/>
C. LPNs . . . . .	6.7	0.0	<input type="checkbox"/>	B. Audiologist . . . . .	0.0	0.0	<input type="checkbox"/>
D. Ancillary nursing personnel . . . .	2.8	0.0	<input type="checkbox"/>	15. Respiratory therapy services:			
4. Certified Nurse Midwives . . . . .	0.0	0.0	<input type="checkbox"/>	A. Respiratory therapists . . . . .	6.2	0.0	<input type="checkbox"/>
5. Nurse Anesthetists . . . . .	0.0	0.0	<input type="checkbox"/>	B. Respiratory therapy technicians . . . .	0.0	0.0	<input type="checkbox"/>
6. Physicians assistants . . . . .	0.0	0.0	<input type="checkbox"/>	16. Psychiatric services:			
7. Nurse practitioners . . . . .	0.0	0.0	<input type="checkbox"/>	A. Clinical psychologists . . . . .	0.0	0.0	<input type="checkbox"/>
8. Medical record service:				B. Psychiatric social workers . . . . .	0.0	0.0	<input type="checkbox"/>
A. Medical record administrators . . . .	0.0	0.0	<input type="checkbox"/>	C. Psychiatric registered nurses . . . . .	0.0	0.0	<input type="checkbox"/>
B. Medical record technicians (certified or accredited) . . . . .	0.8	0.0	<input type="checkbox"/>	D. Other mental health professionals . . . .	0.0	0.0	<input type="checkbox"/>
C. Other Medical record technicians . .	0.0	0.0	<input type="checkbox"/>	17. Chemical dependency services:			
9. Pharmacy:				A. Clinical psychologists . . . . .	0.0	0.0	<input type="checkbox"/>
A. Pharmacists, licensed . . . . .	2.6	0.0	<input type="checkbox"/>	B. Social workers . . . . .	0.0	0.0	<input type="checkbox"/>
B. Pharmacy technicians . . . . .	2.0	0.0	<input type="checkbox"/>	C. Registered nurses . . . . .	0.0	0.0	<input type="checkbox"/>
C. Clinical Phar-D . . . . .	0.0	0.0	<input type="checkbox"/>	D. Other specialists in addiction and/or in chemical dependency . . . . .	0.0	0.0	<input type="checkbox"/>
10. Clinical laboratory services:				18. Medical Social workers . . . . .	0.9	0.0	<input type="checkbox"/>
A. Medical Technologists . . . . .	3.5	0.0	<input type="checkbox"/>	19. Surgical technicians . . . . .	0.0	0.0	<input type="checkbox"/>
B. Other laboratory personnel . . . . .	3.6	0.0	<input type="checkbox"/>	20. All other certified professional & technical . . . . .	11.1	0.0	<input type="checkbox"/>
11. Dietary services:				21. All other non-certified professional & technical . . . . .	23.7	0.0	<input type="checkbox"/>
A. Dietitians . . . . .	0.0	0.0	<input type="checkbox"/>	22. All other personnel . . . . .	33.6	1.0	<input type="checkbox"/>
B. Dietetic technicians . . . . .	2.6	0.0	<input type="checkbox"/>				
				TOTAL . . . . .	144.7	2.2	

\*\* Full-time + Part-time specified in Full Time Equivalent

\*\*\* Please check if contract staff is used.

SCHEDULE K - MEDICAL STAFF\*

State ID 09245

	(1) Number of Active and Associate Medical Staff (Include Board Certified)	(2) Number of Active and Associate Medical Staff Who Are Board Certified	(3) Number of House Staff Who Are Interns, Externs or Residents
1. MEDICAL SPECIALTIES:			
A. General and family practice	<u>2</u>	<u>2</u>	<u>0</u>
B. Pediatric	<u>1</u>	<u>1</u>	<u>0</u>
C. General internal medicine	<u>0</u>	<u>0</u>	<u>0</u>
D. Psychiatric	<u>0</u>	<u>0</u>	<u>0</u>
E. Neonatologist	<u>0</u>	<u>0</u>	<u>0</u>
F. Cardiologists	<u>0</u>	<u>0</u>	<u>0</u>
G. Neurologists	<u>0</u>	<u>0</u>	<u>0</u>
H. Other medical specialties	<u>22</u>	<u>22</u>	<u>0</u>
2. SURGICAL SPECIALTIES:			
A. General surgery	<u>1</u>	<u>1</u>	<u>0</u>
B. Obstetrics and gynecology	<u>0</u>	<u>0</u>	<u>0</u>
C. Perinatologists	<u>0</u>	<u>0</u>	<u>0</u>
D. Gynecology	<u>0</u>	<u>0</u>	<u>0</u>
E. Orthopedic	<u>1</u>	<u>1</u>	<u>0</u>
F. Neurosurgeons	<u>0</u>	<u>0</u>	<u>0</u>
G. Cardiovascular	<u>0</u>	<u>0</u>	<u>0</u>
H. Gastroenterology	<u>0</u>	<u>0</u>	<u>0</u>
I. Other surgical specialties	<u>0</u>	<u>0</u>	<u>0</u>
3. OTHER SPECIALTIES:			
A. Pathology	<u>0</u>	<u>0</u>	<u>0</u>
B. Radiology	<u>1</u>	<u>1</u>	<u>0</u>
C. Anesthesiology	<u>0</u>	<u>0</u>	<u>0</u>
D. Other specialties	<u>0</u>	<u>0</u>	<u>0</u>
4. DENTAL SPECIALTIES:	<u>0</u>	<u>0</u>	<u>0</u>
TOTAL	<u><u>28</u></u>	<u><u>28</u></u>	<u><u>0</u></u>



## SCHEDULE L - PERINATAL\*

State ID 092451A. Name of person completing Perinatal survey Dianne McClure1B. Telephone Number (731) 986-73351C. Fax Number (731) 986-7288

Please complete the following questions.

## 2. Births

A. Total number of live births 1B. Birth weight below 2500 grams (5lb 8oz) 0C. Birth weight below 1500 grams (3 lb 5oz) 13. Number of babies on ventilator longer than 24 hours 04. Number of babies received from referring hospitals for neonatal management 0

YES NO

5. Is Medical Director of Obstetrics board certified/eligible in maternal-fetal medicine?

☐ ☒

6. Is Medical Director of the Nursery board certified/eligible in neonatal-perinatal?

☐ ☒

7. Do the following subspecialty consultants spend more than 2/3 full-time effort at your hospital?

## A. OBSTETRICS:

Perinatal Sonologist ..... ☐ ☒Hematologist ..... ☐ ☒Cardiologist ..... ☐ ☒

## B. NEONATAL:

Pediatric Radiologist ..... ☐ ☒Pediatric Cardiologist ..... ☐ ☒Pediatric Neurologist ..... ☐ ☒Pathologist ..... ☐ ☒Pediatric Surgeon ..... ☐ ☒

**SCHEDULE M - SURVEY ON NURSING PERSONNEL\***

State ID 09245

(As of the last day of the reporting period)

**1. Registered Nurses**

HIGHEST EDUCATION LEVEL	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS	PRIMARY ROLE (NUMBER OF POSITIONS)	
					CLINICAL	ADMINISTRATIVE
Total	27.9	1.0	0.0	0.0	34.0	8.0
Bachelors Degree	9.0	0.0	0.0	0.0	8.0	1.0
Associate Degree	13.9	1.0	0.0	0.0	23.0	5.0
Diploma	0.0	0.0	0.0	0.0	0.0	0.0
Masters Degree	5.0	0.0	0.0	0.0	3.0	2.0
Doctorate Degree	0.0	0.0	0.0	0.0	0.0	0.0

**2. Advanced Practice Nurses**

NURSING PERSONNEL CATEGORY	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS	PRIMARY ROLE (NUMBER OF POSITIONS)	
					CLINICAL	ADMINISTRATIVE
Total	1.2	0.0	0.0	0.0	1.0	1.0
Nurse Practitioner	0.0	0.0	0.0	0.0	0.0	0.0
Clinical Nurse Specialist	1.2	0.0	0.0	0.0	1.0	1.0
CRNA	0.0	0.0	0.0	0.0	0.0	0.0
Certified Nurse Midwife	0.0	0.0	0.0	0.0	0.0	0.0

**3. Licensed Practical Nurses**

LPNs	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS
Total	0.0	0.0

**4. Recruitment of Nursing Personnel**

The following are selected specialties for which hospitals commonly report recruiting difficulties.

Please specify other categories as necessary.

NURSING PERSONNEL CATEGORY	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS
CCU/ICU	3.2	0.0	0.0	0.0
ER	5.8	0.0	0.0	0.0
Other (Specify):				
	18.9	0.0	0.0	0.0
	0.0	0.0	0.0	0.0

Plans:

Revisi